Information Exchange Workgroup
Draft Transcript
June 1, 2012

Presentation

MacKenzie Robertson - Office of the National Coordinator

Thank you. Good morning, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Information Exchange Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please be sure to identify yourself when speaking. I'll quickly go through roll and at the end ask any staff members to also identify themselves. Micky Tripathi.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Here.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Micky. Hunt Blair. Tim Cromwell. Jeff Donnell.

Jeff Donnell – NoMoreClipboard - President

Here.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Jeff. Judy Faulkner. Seth Foldy.

Carl Dvorak – Epic Systems – Executive Vice President

This is Carl Dvorak attending on behalf of Judy.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Carl.

Seth Foldy – Centers for Disease Control and Prevention

Seth Foldy is on.

MacKenzie Robertson - Office of the National Coordinator

Seth Foldy, thank you, Seth. Jonah Frohlich.

Jonah Frohlich – Manatt, Phelps & Phillips, LLP

Here.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Jonah. Larry Garber.

Lawrence Garber – Reliant Medical Group

Here.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Larry. Dave Goetz. James Golden. Jessica Kahn. Charles Kennedy. Ted Kremer. Arien Malec. Sorry, did I miss someone?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Cris Ross is here.

MacKenzie Robertson - Office of the National Coordinator

Cris Ross. Deven McGraw. Stephanie Reel. Steven Stack. Chris Tashjian. John Teichrow. Amy Zimmerman and Cris Ross, I got you. Are there any staff members on the line?

Michelle Nelson – Office of the National Coordinator

Michelle Nelson.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Michelle.

Tari Owi – Office of the National Coordinator

This is Tari Owi from ONC.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Tari. Okay, Micky, I'll turn it over to you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay, great. Thanks, MacKenzie. Good morning, everyone. Welcome to the Information Exchange Workgroup call. Today we're going to be discussing, getting a readout from one of our Subgroups. We broke up into three Subgroups to attack different parts of the governance RFI and today we're going to be hearing from Subgroup 3, which has been very ably led by Jeff Donnell, that's focused on the interoperability CTEs and economic impact areas.

So, we'll be diving into that in a second. The Subgroup has been hard at work looking at the questions, both the priority and the secondary questions that have been assigned to the IE Workgroup in that area. So, what we're going to do is go through those questions in order. Jeff will lead us through that and with the Workgroup we'll be hearing from the Subgroup on what their recommendations are in the way of response to the various questions, what some of their thinking was behind that and then we'll take each question in turn I think and then have a Workgroup discussion about where the Subgroup ended up and what our thoughts are on the recommendations coming out of the Subgroup.

Thinking about just the overall picture here, before I turn it over to Jeff, we have three Subgroups, as I said. Two of those Subgroups are going to be meeting later this afternoon and next week the Information Exchange Workgroup as a whole will be meeting on Monday and Tuesday in anticipation of finalizing our comments on this RFI for the presentation to the HIT Policy Committee on Wednesday. So, on Monday we'll be hearing from Subgroup 2, which is being led by Cris Ross to discuss their thoughts and recommendations. And then on Tuesday at the IE Workgroup meeting we will do any last thoughts on the findings from Subgroup 2 and Subgroup 3 and then we'll also be talking about Subgroup 1, which I'm leading.

And then in anticipation of at the end of the day wrapping up whatever final comments we have in all of those areas and then I'll be presenting that to the Policy Committee on Wednesday. So, very much appreciate everyone's attention to this. I know it's been a very high level of intensity as we're dealing with the ONC and CMS NPRMs and then moved very quickly into this RFI and I really, really appreciate everyone's engagement on all of these things because I think they're incredibly complex, but incredibly important that we have as broad a perspective as we can offer to the Policy Committee and to ONC and CMS on these issues.

So, let me turn it over to Jeff then to walk us through the Subgroup 3 findings.

Jeff Donnell – NoMoreClipboard - President

Okay, thank you very much. This is Jeff Donnell and what I'll do is I'll walk you through where we're at. We did have our second meeting yesterday afternoon to go through our secondary questions and I know I didn't receive the write up of that until late last night and really have not had a chance to go through it in detail yet. So, we'll be probably doing a little bit of clean up this weekend, just to make sure everything is accurate. And I'm sure that after today's call there may be a little bit of additional refinement, but we'll make sure all that is complete by the end of the weekend.

MacKenzie Robertson - Office of the National Coordinator

Hi, Jeff. Sorry to interrupt. Do you want the Word document to be shown during the Webinar to speak from or do you just want to talk?

Jeff Donnell – NoMoreClipboard - President

You could put the Word document up, that would be fine.

MacKenzie Robertson - Office of the National Coordinator

Okay, great.

Jeff Donnell – NoMoreClipboard - President

That might help people as we go through this. We'll start by going through the priority questions that we were asked and really the initial focus or the primary focus is on the economic, the potential economic impact of the CTEs in establishing NVEs. And just one overall comment, our group felt that ultimately NVEs would probably come in a variety of shapes and sizes. There would not be sort of the one size fits all, so I think that gives a little bit of context for the discussion overall. But, I'll walk through these and if anyone has any questions or comments as we're going, please interject.

One of the questions we were asked is about the potential cost of validation. And where we arrived is we believe that the cost of validating NVE should vary greatly, depending on the range of services that the different NVEs might apply, which CTEs apply to those services, what potential use case an NVE is involved in. So, again, we don't envision sort of a one size fits all validation process. We certainly believe that costs for validation should be reasonable and minimize as much as possible. We don't want to place undue burden on the entities that want to operate as an NVE.

And we want to make sure that especially those that are around who operate directed exchange services that would support Stage 2 Meaningful Use should be low enough that virtually anyone who wants to should be able to participate. And we had, I think, pretty good unanimous agreement around that.

The next question is around potential savings to states or other organizations that could be realized with the establishment of a validation process for CTEs. Overall, we believe that the proposed governance approach is going to benefit the states. It's going to, we think, encourage greater participation in Health Information Exchange, ultimately improving quality and reducing the cost of care. Thus far only a few states have established their own accreditation or certification programs for HIEs and we believe a national governance program is going to allow those dates to eliminate certification programs, which would produce some clear cost savings.

One caveat to that, which came to this which came up yesterday is certainly every state has its own laws, each state's officials are certainly going to look at how do those state's laws and regulations apply and there's going to have to be a certain level of trust that gets established in this national approach before we see the states really embracing this.

The next question is around the potential--

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Jeff, can I just stop you for a second? I just wanted to pause first and see for these two if anyone had any comments or thoughts. I had just one question and I guess it seems like the first question is potential cost of validation is a little bit of a bottom up, right? I think that the focus of that is what would be the cost of validation, for an NVE what would be their cost? And then the second question is a little bit more of a top down, right, if I'm understanding that right?

Jeff Donnell – NoMoreClipboard - President

Correct.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

And so, I'm just wondering; the comment that's really in the second one, which is about it saving money for the states, it seems like there's something related to question number one, which is that many organizations I would think who are interested in being NVEs do not want to have separate state processes and would much prefer to have a single national process and I would think that that would be a source of savings and value to them.

Jeff Donnell – NoMoreClipboard - President

Good point, and I think from an NVE point of view it would be an absolute nightmare to have to navigate different validation processes and not only the burden of being able to comply with those various processes, but then the additional cost.

Carl Dvorak – Epic Systems – Executive Vice President

I was going to add a comment, too. I think the first comment on the cost, I agree with where we're headed there and one possible differentiator might be organizations that send and receive records for themselves, i.e., a health system who is directly providing care versus organizations that tend to receive documents on behalf of others, an intermediary as it were.

And then, secondly, what feels lacking a little bit is some overt guidance to states that basically says there's wisdom in following a federal validation process and maybe provide guidance that they could vary the consent or the opt in/opt out sort of thing at the endpoints, but where possible following the federal validation approach is the magic that would reduce cost and enhance interoperability, especially across state lines and so many of these state lines are really artificial in context of the populations. So, it would be nice if we had something a little bit more overt and explanatory with regard to how to save states' money and how states could follow along in an effort to improve interoperability.

Seth Foldy – Centers for Disease Control and Prevention

I agree with what was just said and I do believe that as a general rule the document we're looking at fails to hit the target. In other words, the state restrictions that every health lawyer has to examine for every participant in every HIE today are typically written into state laws and are created to set a certain level of protectiveness. To establish truly national low friction exchange the, as I see it, the Nationwide Health Information Network has to be sufficiently robust that state legislatures would effectively say we can start standing down some of our standalone laws and start, if you will, adopting the Nationwide Health Information Network by reference.

In other words, we point to those principles and those safeguards rather than constantly creating new state level safeguards. But we run into a problem. If the Nationwide Health Information Network is going to have robust safeguards and at the same time is going to somehow prescribe the right safeguards for every kind of health information exchange that is envisioned, for example, in meaningful use, so that includes clinical care, billing, medical research, public health reporting, there is no one size that fits all.

You can't have patient consent and still have effective public health mandated reporting, for example. I see that we have a dilemma with the current rules. They're neither robust enough to overcome the state's compulsion to establish lots of privacy protections that are idiosyncratic to the state, nor are they flexible enough to meet the needs of multiple different use cases and unless the different use cases are kind of spelled out and addressed flexibly the more robust you make it, the less suitable they are for multiple activities.

I'm sorry to be longwinded about this, but I've tried to put together a few paragraphs about this that I'll share with the Committee by e-mail.

Carl Dvorak – Epic Systems – Executive Vice President

Seth, I generally agree with you and would just add that the CMS Medicare participation is a lever that could affect that to some extent with states, including the Medicaid contributions.

Seth Foldy – Centers for Disease Control and Prevention

Yes, if there are levers that could be used beyond just getting everybody to trust these rules. I concur.

Jeff Donnell – NoMoreClipboard - President

Any other questions or comments?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So, it sounds like with both Carl's and Seth's comments that maybe there's something to write in here about the value from a bottom up perspective of having something that is more approaching a federal standard than exists today, where nothing exists today, but the value of that from a bottom up perspective, not just from a top down perspective and also, perhaps, the need to offer more guidance with respect to what might be the common denominator set of things that every state ought to be able to agree to or ought to be able to be a common denominator set of things that they could point to and not feel the need to have local variation around.

But I think to Carl's point there's always going to be a small set of things probably for a very long time if not forever that are going to be local, but hopefully more focused on the endpoints than on the sort of the NVEs per se.

Jeff Donnell – NoMoreClipboard - President

Great comments. Thank you very much. And we'll update our draft comments to reflect that. Okay the next question, really the next two questions are very closely related. The first one has to do with the potential increase and the secure exchange of health information that might result from the establishment of CTEs and we foresee a significant increase in Health Information Exchange that would result from the closed government structure and that would include non-traditional Exchange participants.

And that really leads to the next question in terms of the potential number of entities that might seek to become NVEs. And, again, we don't envision the one size fits all type of NVE. We envision a variety of shapes and sizes offering a variety of services and if that's the case and we account for that in everything – the validation, the reporting requirements of cost – then we actually envision that you could have thousands of entities pursuing NVE stats. And, conversely, if we've got a minimum set of services that's very far reaching in scope and the cost for validation and the reporting requirements and those sorts of things are high, then that would probably limit the number of people that would seek to become an NVE.

Under that first scenario our belief is that you would have, again, perhaps thousands, of organizations and that would certainly include traditional Exchange participants, you know, RHIOs, HIOs, but as well as EHR vendors, patient engagement vendors, hospital and health systems, academic centers, you know, it could be incredibly robust and clearly the folks that are already providing Health Information Exchange services with the ideal NVE candidates, but we believe that there will be others as well.

And, again, back to some of the earlier comments, very much like looking at EHR certification as we came up with the national standard for that, as you had multiple certification bodies, all of a sudden that led to we're at the point now we have, I believe, it's close to 800 certified Electronic Health Record vendors and some of them are complete systems, some of them are modular and we envision something similar happening in the NVE space.

Any questions or comments on those two items?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Jeff, I had one question that might be worth teasing out in the comment. It's a question and then depending on what the answer is it might be worth teasing out, which is did the Subgroup discuss what you thought the drivers of value were for an NVE? I mean, if we're saying that we think that there could be thousands that decide to pursue NVE status, what did you as a group think were the main drivers of value for a prospective NVE?

Jeff Donnell – NoMoreClipboard - President

We talked a little bit about that. We're certainly already seeing, for example, hospitals and health systems starting to set up what amounts to their own Health Information Exchange within a particular health system so we would envision that for organizations like that becoming an NVE and perhaps making it easier for data to be shared on a broader basis would make sense.

We also talked about the fact that if you look at, perhaps, some of the proposed Stage 2 Meaningful Use requirements for EHR vendors, for example, you look at patient engagement and the proposed requirement the EHR vendors would enable patients to be able to view, download or transmit their information. If you look at that transmittal piece, all of a sudden you're talking about Exchange and a patient might direct that they want their health information shared with another individual, a practice hospital, another entity, so we envision that EHR vendors might see a potential opportunity there.

And in some cases there might be monetary gain and in other cases it comes down simply to compliance with newly envisioned Meaningful Use recommendations.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

And I know one of the challenges with breaking up our consideration of these is that the questions aren't wholly independent so it may be that the group didn't discuss this, but I'm just wondering if there was any concern discussed in the group about things that could be barriers to people becoming an NVE? So, for example, the requirement that an NVE follow covered entity requirements from a HIPAA perspective or the prohibition of commercializing de-identified data that may be used as well.

Jeff Donnell – NoMoreClipboard - President

I don't know that we got into that in any detail. Seth, do you recall any conversations about that?

Seth Foldy – Centers for Disease Control and Prevention

Not directly.

Carl Dvorak – Epic Systems – Executive Vice President

I would be a strong voice for trying to make this as permissible as possible and the simplest possible in the spirit of innovation. I think that the potential for some of these consumer device companies that could stream really high value data into electronic health systems might qualify as well and to the extent we can make it simple and accessible by many; I think we could open up a lot of access to a wealth of apps and devices out there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. Is there anything, Carl, that you were thinking of specifically that would prohibit that right now?

Carl Dvorak – Epic Systems – Executive Vice President

Well, I think being careful to not decide who is and is not an endpoint, who is and is not an NVE. I think sometimes we approach this with our predetermined notions of a configuration. I know we do that sometimes here and I know others do it as well. But I think to the extent possible to imagine what NVEs might be like in ten or 15 years, which is likely how long we'll live through these regulations, if not longer, would be wise.

Seth Foldy – Centers for Disease Control and Prevention

There is, in earlier parts of the RFI, a proscription on any commercial use of the information being exchanged and without the term commercial use being defined it's hard to know, but it seems to me that app developers, market researchers, there's a whole variety of things that we would probably commonly consider commercial use, would be proscribed as a user of data or really that the NVE would be prohibited from exchanging data with such entities. And, of course, that might affect the sustainability of the NVEs.

Carl Dvorak – Epic Systems – Executive Vice President

Yes, I think that's a good comment, Seth, especially in context of even an ACO is a commercial entity in some regards and sometimes the companies that might help do case management or provide utilization review services to an ACO would certainly be a commercial entity. We have to be very careful.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Just speaking up from Workgroup 2, we'll be reporting on Monday; we had a fairly robust conversation on that particular topic. To Micky's point these things really hold together and decisions around policy here may be informed more or less by decisions made about commercial use of data and so on. I can say that the consensus of that group was that there ought to be some permissible uses of data believing that that was important both for the NVE, but also to Carl's point, to people who would depend on an NVE to do care management, to participate in ACO and other forms of innovation. So, I think we should look at all of it together when we get input from all the Workgroups.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That makes sense. And certainly sweeping statements like commercial uses can resonate for a long time with tons of unintended consequences down the road. We're not really precise about what we mean by that.

Jeff Donnell – NoMoreClipboard - President

Absolutely. Okay, I'll move along to the next question, question five, which is the NVE application or reporting burden associated with the conceptual proposals. And our comments there, we really don't have an estimate in terms of the application of reporting burden, but, again, we would envision that that's going to vary greatly depending on what Exchange services are offered, what CTEs need to be validated. Certainly, again, we would expect that the application and reporting burden should be kept at a reasonable level so that we encourage NVE participation and do permit some modest fees for NVE customers.

And, again, I think goes back to what we were just discussing that to the extent that we keep things relatively simple, we keep the burden relatively low, then I think we believe we'll see significant interested organizations becoming NVEs, but the core requirements that we put around it, as those become older, then that's going to stifle innovation.

Another thing that was discussed was then, to reduce cost and burden is are there ways to perhaps automate the validation and auditing of some of the CTEs. Any comments or questions on that before we move on to the secondary questions that we were asked to consider?

Okay, hearing none I'll go ahead and get into the secondary questions and these were the items that we discussed yesterday, so in going through these quickly this morning I think there's a little bit of clean up that's required, but we'll get that taken care of right away. And these had to do with certain conditions. So, the first condition I1 is that an NVE has to be able to facilitate exchange in two circumstances, one when the sender and receiver are known and, two, when the exchange occurs at the patient's direction.

So, the questions related to that condition, first of all, what types of transport methods or standards should NVEs be able to support? Should they support both types, SMTP and SOAP, or only have to meet one of the two as well as have a way to translate like XDR and XDS?

And, overall our belief is both that an NVE should be able to support both forms of transport, both SMTP and SOAP because different entities are going to be able to work with different transport methods. And, Seth, this is where I think there is a little variance from the discussion yesterday. If I recall correctly, you said that SOAP is the one that's the standard that public health is focused on as opposed SMTP. Is that correct?

Seth Foldy – Centers for Disease Control and Prevention

Especially for the exchange of information around immunization registries, yes.

Jeff Donnell – NoMoreClipboard - President

Yeah, because whoever took the notes here put down SMTP, so that's a little bit backwards. But, again, I think the consensus from our group is that really we ought to support both so that, again, we foster robust exchange.

Carl Dvorak – Epic Systems – Executive Vice President

Can I offer a dissenting opinion, Jeff?

Jeff Donnell – NoMoreClipboard - President

Sure.

Carl Dvorak – Epic Systems – Executive Vice President

I really see that as a tragedy in our ability to select a standard early in this process especially before almost a billion dollars is granted out for projects for state-based entities and such. And I think enforcing that everybody support both just perpetuates an extremely costly situation. I'd be an advocate for let people certify and tag the certification with which they support and to gracefully let one die as soon as possible so that we can get out from under an unnecessarily costly scenario.

Seth Foldy – Centers for Disease Control and Prevention

I guess the only question then would be you may have entities that connect, that use one form of connectivity, of transport, that the end user doesn't accept in some cases and other end users that don't accept the other in other cases. I mean it is; I don't disagree with the problem you're raising, but it seems like it creates a second problem.

Carl Dvorak – Epic Systems – Executive Vice President

I agree with you, Seth. I think if, in fact, both have value then both will perpetuate and exist. If it turns out that both don't have value, one will die quickly. And it's harsh, but I worry that through this regulation we're artificially increasing the cost of care.

Seth Foldy – Centers for Disease Control and Prevention

And this may actually go to my contention that if this process doesn't, in a sense, define the use cases, again, it goes back to the question of can one NVE meet every possible use case? And the answer is yes. But can an NVE meet every possible use case with a single set of CTEs the answer might be no. And this kind of kept forcing me to look at the idea that there may need to be defined use cases.

So, if an NVE represents itself as the best way to exchange information with public health it may need to then support certain approaches that might be very different than if an NVE represents itself as a great way of exchanging patient transfer of care information.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I sort of had the same concerns I think that Carl is expressing. I was wondering whether a different way of approaching this is to tie it to the transport requirements that will be a part of ongoing HER certification requirements. So, the concern I have in looking through this is that we're creating another certification system that could be completely at odds with what the EHR vendors are going to be certified for.

So, we basically say something like the transport requirements ought to be the same as EHR vendors are being required to be certified for.

Jeff Donnell – NoMoreClipboard - President

So that we have harmonization between the two.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes. Carl, how would you feel about that?

Carl Dvorak – Epic Systems – Executive Vice President

Can you summarize? I was trying to parse that all out. What's the summary statement there?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Sorry, yeah, it was basically to say that the transport requirements for the NVEs ought to be the same as whatever transport requirements are a part of the EHR certification requirements that would be the ongoing rules coming out of ONC.

Carl Dvorak – Epic Systems – Executive Vice President

I would agree with that. Micky, maybe I would add that would be the minimum set. It does not mean they could not also have additional.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Absolutely, right, minimum.

Seth Foldy – Centers for Disease Control and Prevention

I mean, it seems to contradict what Carl was saying in that it creates, if you will, the government is putting its thumb on the balance saying both of these will succeed. It wouldn't permit a method to die out spontaneously, but I suspect we can't do much better.

Carl Dvorak – Epic Systems – Executive Vice President

Micky, just to modify that we do have to sort of have a domain in mind. I don't know that all lab interfaces would need to migrate to a SOAP or to an SMTP standard when there's a perfectly acceptable HL7 standard that's tried and true. So, I would restrict my comments to be within the domain of Health Information Exchange around; it would be interesting, I can't even articulate the domain, but I've got a sense that there's a domain there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah, I mean, I guess what I was thinking generally was we'll see where this process ends up, but let's just say that the 2014 edition rule ends up with the Standards Committee recommendation, which is SMTP and HL72.5.1, then we would simply be saying that the NVE requirement would be the same.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Just briefly, just reporting in to what's been discussed at the NwHIN Power Team as part of the Standards Committee, similar kinds of questions. I think that group is coming down a recommendation to say that an NVE may support whichever ones they see as appropriate and simply indicate to participants into the market which protocols they support, that the protocol supported would to your formulation, Micky, line up with what's required for certified EHR technology, but essentially allow NVEs to make clear which protocols they will support and to provide capabilities to do translation from one protocol and message type to another, so to not be restricted to say that they must support any particular one or that they must do all, that they simply must implement whatever suits them.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So, they wouldn't even be required to do the ones that are specified in the ONC rules for EHR certification?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Well, I think part of that discussion was that we could imagine an NVE that might serve just one purpose, for example. Perhaps they would support only SMTP or perhaps they would only support XDR or perhaps they would be lab vendor or perhaps an ePrescribing network that wouldn't support either SMTP, XDR or SOAP because they have existing methods in place.

So, those vendors could simply say, you know, the only thing we do is this one purpose, so therefore we're going to use a RESTful transport specification in support of HL7, for example, and that that's the only purpose for which our network serves.

Carl Dvorak – Epic Systems – Executive Vice President

I agree with that. I think if we're going to have two and allow two, I don't think that anyone should be mandated to do both in an interest to reduce cost and ultimately arrive on a single standard if that were to be appropriate. And the reason to not do two is we might find that two has some limited utility. If I'm the iHealth blood pressure cuff person attached to an iPod, I might want to do an SMTP thing and just that and that might be wonderfully sufficient.

If I'm an HIE moving data on behalf of thousands of providers in an urban area that might be insufficient. So, I think if we're going to allow both we should be careful not to mandate both or we will ultimately stack motivation.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Yeah, that Workgroup also discussed that an NVE may be like a hybrid entity under HIPAA, that they may do things that are regulated under CTE, but they may also want to have other functions that are not included in the NVE definition and governed by CTEs. An example that we thought through was perhaps something that had purely a patient connectivity piece or perhaps it was an NVE that carried clinical data, but also carried, for example, administrative data on behalf of payer functions.

I don't want to cross fertilize here too much, but I thought I'd give a heads up to at least what one other group is talking about.

Jeff Donnell – NoMoreClipboard - President

No, I think that's interesting. I guess I had just thought that one value of the NVE process would be that an prospective user of an NVE would at least have the confidence that whatever is being required from a transport perspective for whatever use cases are specified in the EHR certification process, that at least I would be able to perform those with this NVE for the use cases that the NVE does. I mean, if they don't do labs, then clearly they don't need to worry about a lab specification.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Sure, absolutely. I think we observed in that Workgroup the likelihood that many NVEs would seek to become multi-gauge and that they would present as a virtue the ability to translate from one environment to another to take patient-facing data and be able to present it to a robust EHR environment using a SOAP interface. The market will probably work that out.

Seth Foldy – Centers for Disease Control and Prevention

So, what we don't know and the situation I'd be concerned about is you imagine that things tend to collapse back towards an NVE serving multiple functions in a geographic space. And then you have an NVE that has, for example, effectively excluded providers from being able to use it to connect to immunization registries. It's hard to assess the likelihood of that scenario, but it would then undercut some of the key objectives, for example, of the meaningful use.

Jeff Donnell – NoMoreClipboard - President

Well, I think if we go back to that concept that NVEs should not be one size fits all and that we look at a range of potential use cases I think where this discussion is headed does seem to make sense, that rather than requiring that everyone support one or that everyone must support multiple standards that we leave it to the NVE to determine what's going to be best, determining the clients they serve, the use cases that they're involved in and, again, some will choose to be multi-gauged, to be able to adhere to a wide variety of standards and to translate between them. Whereas those others, who maybe have a very narrow focus they do exactly what they need to do to support that narrow focus.

I'm comfortable with where the discussion is headed. Seth, how do you feel about it?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Well, while we're waiting for Seth, let me just make sure I understand and just put a fine point on it since I'll be presenting this at the Policy Committee, I want to be able to represent it accurately. And, Cris, let me just draw you in again. So, the NwHIN Power Team, was there any concern expressed that there may be at least a perception of a policy disconnect to the extent that we have an EHR certification process, whether we agree with it or not is a separate question, but an EHR certification process that is specifying transport requirements on EHR vendors, but then we're going to have an intermediary essentially, an intermediary validation process, also federally determined that does not require that they meet those transport requirements.

Carl Dvorak – Epic Systems – Executive Vice President

It's one way to say that, basically to say allow for CTEs to be more or less split or portioned, to be CTE for purpose X, CTE for purpose Y, or method A, method B, method C where appropriate.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I think that was exactly the intent, Carl, or the discussion. Agreed with you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So, how would that work? That would mean?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

You'd get your SMTPS MIME badge, you'd get your XDR badge, you'd get your RESTful badge I think was the idea and that NVEs would indicate for what purpose they're suited. I don't think that our group had a particular discussion that we thought that it would necessarily be that there would be that mismatch. I think the belief was that the commercial market would generally drive NVEs to be multi-purpose. But they may want to simply be a single purpose vendor. I'm thinking about the significant number of lab vendors who would have no reason to adopt SMTPS MIME or SOAP, except in some … case their core business could continue to operate on a RESTful standard.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay.

Seth Foldy – Centers for Disease Control and Prevention

And public health is always in this world where perhaps the biggest fear is that some restriction will be put into place that will force the entire public health enterprise to rip and replace its messaging, its transport. So, having an Open, if you will, an Open gauge is friendly to maintaining what is, of course, unfortunately a bit of a multiple gauge railroad system, but it doesn't force a lot of ripping and replacing.

On the other hand, if you start to narrow it down, then it becomes critical that at gauges that we know are becoming part of the future direction of a substantial part of the public health enterprise, like immunization registries, then they have to be included.

So, if you're saying we're going to create a Direct world, and Direct doesn't really meet the public health use case, we have a big problem. If you say we're going to leave an Open world, we have less of a problem, but, of course, that still leaves the issue of different trading partners trying to figure how they're going to do their business. I wish I could be clearer than that, but you can see that we're stuck in a dilemma on that one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So, Seth, is that just a cautionary note?

Seth Foldy – Centers for Disease Control and Prevention

Well, to be more specific, I think if the CTEs said everybody must do Direct and may do something else, it raises the concern that everyone will, in fact, do Direct and not do anything else and that we'll kind of be stuck.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I agree with you, Seth, because I don't see the Direct project as sufficient for the long term, although it may have utility along the way, I don't know that that's sufficient for the future of interoperability and I agree, if it became mandatory to the optionality of the other it would accidentally become that and it would probably be a setback for interoperability for at least a decade.

Seth Foldy – Centers for Disease Control and Prevention

So, the only reason I'm saying insert SOAP is to try and prevent a monoculture that may not work in the long run for public health. So, I could take away any requirement to insert SOAP, as long as we don't prematurely create a dysfunctional monoculture.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

And what would in your mind create that dysfunctional monoculture? Because it seems like where we're headed, if I'm understanding where this conversation is headed, is towards something that's more along the lines of what Cris was describing the NwHIN Power Team is headed, which is to say that there should be no stipulated transport requirement to be an NVE and rather let's let the market determine how it wants to sort of; an NVE will determine itself what standards it wants to use and we'll publish those and it will be sort of CTE grab bag associated with each of the modes it wants to have and that will be basically a market determined phenomenon.

Seth Foldy – Centers for Disease Control and Prevention

Yeah, Micky, you've gotten to the limits of my technical and economic free market capabilities here. I can't predict the future. I'm not sure I have any problem with that right now.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. The big question is, it seems to me, do we want to say anything along the lines of a requirement, either as written here, which is specifying some requirements, or saying that it should be tied to the EHR certification process or really nothing at all, that it's really just about transparency and having NVEs offer to the market what they think is valuable and it seems like we're headed for the last one.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I think I would suggest that we make it that it be the last one; however, that any standards that are adopted be the equivalent for what's required for certified EHR technology. That is assuming that the RESTful protocols proposed in the NPRM survive and are included, only because there's so much of the industry that's built on that today. That would be my opinion and I think congruent with what was talked about with the Power Team.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Is everyone comfortable with that?

Seth Foldy – Centers for Disease Control and Prevention

Could it be restated what it would sound like? I'm not sure I understood the difference between the first option and the last option.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

The last option I think is and, Cris, correct me if I'm wrong, is that an NVE should be able to adopt whatever standards it wants to, but if they adopt a standard that is part of the EHR certification process they should be aligned with that standard that is specified in the EHR certification.

Seth Foldy – Centers for Disease Control and Prevention

Works for me. Thanks.

Carl Dvorak – Epic Systems – Executive Vice President

That works for me as well.

Jeff Donnell – NoMoreClipboard - President

I'm on board.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Great.

Jeff Donnell – NoMoreClipboard - President

Okay. Well, moving along and I think that the next comment had to do with RESTful and I think RESTful falls into the same category as what we just discussed. The next condition that we considered is I2, which is that an NVE must follow required standards for establishing and discovering digital certificates. And the question is are the technical specs, DNS and LDAP, appropriate and sufficient for enabling easy location of organizational certificates, are there other specs that we should also consider and our team felt that DNS and LDAP were appropriate and sufficient for easy location of organizational certificates. It seems to be aligned with other recommendations for certificate discovery from the S&I framework.

So, we were supportive that those two should be sufficient at this point in time. Any additional comment on that one?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So, is what's implied here, let me see if I can go to full screen and see the question; is what's implied here that there would be a standard for discovery? And is that sort of bringing us into the same category as the discussion we just had as a standard for transport?

Jeff Donnell – NoMoreClipboard - President

So, are you suggesting that maybe we ought to take the same approach that we did with transport, which is, again, let the NVEs determine what's most appropriate and let the market ultimately determine what's going to be the best approach?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah, I'm just wondering if that would make it consistent with the way that we were thinking about the transport. It doesn't say that they would use that. It's asking a very specific technical question, so it's not saying that they would necessarily use that as a policy level, but it seems like that's implied.

Jeff Donnell – NoMoreClipboard - President

True. Yeah, and I think the way we looked at it really we responded specifically to the question, which is: Are those the appropriate suggestions?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I don't know how the rest of the Workgroup feels, but I might suggest that we add a bullet that speaks to the principle that we just agreed to for transport.

Jeff Donnell – NoMoreClipboard - President

Yeah, so we could point out that while we believe these two are sufficient that, as above, we would allow NVEs to determine what's going to be most appropriate for them as long as they're transparent with that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Does everyone agree with that?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I'm reluctant to speak up so much, given that I'm on the other Workgroup. I think there's a potential argument that says that the DNS and LDAP specifications are congruent with Directed Exchanged protocols, but that if an NVE were to implement a RESTful protocol, they would more likely use some pretty standard means for web service look up for demographics, for example, to be able to identify an organization and entities within it.

And then within the SOAP world, there's the XCPD or XCDP, that's used for patient identification, for example. So, I think these two standards are congruent with Directed Exchange and for those purposes I think the Workgroups have said there's warts with them, but they're sufficient. But the sun doesn't rise and set just on DNS and LDAP for organizational certificates using other protocols, SOAP protocol or for RESTful.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right, so I think that's what we're saying is basically to add a bullet that says that this NVE validation process should not be specifying DNS or LDAP or anything; they should let the NVEs decide what they're going to do.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Yes, totally agree. Thank you.

Jeff Donnell – NoMoreClipboard - President

So, is everybody comfortable with the addition of that additional bullet?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Sounds like it.

Jeff Donnell – NoMoreClipboard - President

Micky, I know we're approaching our hour time window. How do we want to proceed?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

How many more questions are there here? I can't scroll down.

Jeff Donnell – NoMoreClipboard - President

We've got one, two.

MacKenzie Robertson - Office of the National Coordinator

It looks like there's five.

Jeff Donnell – NoMoreClipboard - President

Yeah, there's still quite a few.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. It looks like, just at a very high level, now I don't want to misrepresent this, but a few of them, like on the patient matching, there are a couple on the patient matching and then there's alignment with the policies of the Federal Bridge. On the patient matching one, it almost seems to me like that would fall in the same category of what we were just talking about with transport and with certificate discovery, that NVE process shouldn't be dictating that.

Jeff Donnell – NoMoreClipboard - President

Yeah, that's exactly where we came down. And certainly right now there's not clear guidance. There's been certainly plenty of work done by Tiger Teams and various entities, but there are no clear standards and when this is especially where it gets sticky is as you look at what's going on in different states and how different groups that would probably become NVEs are handling that today. So, we felt pretty strongly there.

As far as the Federal Bridge, I think we did come down that we ought to at least be consistent there with the policies that are being put in place around the Federal Bridge.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah, how do people feel about that one? You know, again, it's a question of whether we think that's a requirement to be an NVE or that, again, you let the market decide and NVEs just tell the market whether they're aligned with it or not and the market will decide whether that's an important feature or not.

Carl Dvorak – Epic Systems – Executive Vice President

I think a market approach is reasonable, but probably with some guidance to the federal programs to go the extra mile to make that practical and possible.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

How do others feel about that? Cris, has the Power Team sort of picked that up?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

You know, we have really not gotten to that issue yet. What you just described and Carl approved sounds congruent with what we have been talking about.

Seth Foldy – Centers for Disease Control and Prevention

Seth apologies, but needs to sign off. Thank you, everyone.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Thanks. It seems to me that even on that one that, again, just following the thread of logic that we've had for the other ones that we're going to have a market-based approach for all of these that should probably be consistent, even with the Federal Bridge one, unless we have an argument for why that would be different than the other categories.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Exactly. Cris apologizes, I need to drop off as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay.

Jeff Donnell – NoMoreClipboard - President

I think that does make sense.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay.

Jonah Frohlich – Manatt, Phelps & Phillips, LLP

Good call, Micky. I've got to drop as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay, great. Thank you, everyone. Sorry, we have to have the public comment, but appreciate all the Workgroup members joining and I'll turn it back to you, MacKenzie.

MacKenzie Robertson - Office of the National Coordinator

Sure, thanks, Micky. Could you please open the lines for public comment.

Public Comment

Operator

Yes. If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay, great. Well, thank you, everyone. And especially thank you, Jeff, for your help with the Subgroup and for leading us through a challenging set of issues and really appreciate your leadership there.

Jeff Donnell – NoMoreClipboard - President

Well, thank you very much. I appreciate your help as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Great. Thank you.